Health, & Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015135
STATE FILE NUMBER

MAY 1 1959 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 2 3702

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis, Missouri — Inside Limits Yes XX No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St.Louis Children's — Length of stay in 1b 14 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY Marion
c. CITY OR TOWN Vernon — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) -- — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Duane — Middle Allen — Last Holsapple

4. DATE OF DEATH: Month 4- Day 15- Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-8-59

9. AGE (In years last birthday) — IF UNDER 1 YEAR Months 3 Days 7 — IF UNDER 24 HRS. Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Centralia, Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Frank n.m.n. Holsapple

13b. MOTHER'S MAIDEN NAME: Edith Burnett

14. NAME OF HUSBAND OR WIFE: Single

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Alice Trowbridge, 500 S. Kingshighway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): INTERVENTRICULAR SEPTAL DEFECT
TRANSPOSITION OF THE GREAT VESSELS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): ____

DUE TO (c): 754.2

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ASPIRATION PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-1-59 to 4-15-59 and last saw him alive on 4-15-59
Death occurred at 1:20 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Richard Smith M.D.

22b. ADDRESS: 500 S. Kingshighway

22c. DATE SIGNED: 4-15-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 4-17-59

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): Odin, Illinois

24. FUNERAL DIRECTOR ADDRESS: Wilson Funeral Home Odin, Illinois

25. DATE RECD. BY LOCAL REG.: APR 15 '59

26. REGISTRAR'S SIGNATURE: Richard Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ...., Student Embalmer No. ....

working under my personal supervision.

Student .... Signed ....
Signature of Student Embalmer

Licensed Embalmer No......................

P. O. Address..................................

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.